THE
BOSTON MEDICAL AND SURGICAL JOURNAL.

New Series.] Thursday, November 24, 1870. [Vol. VI.—No. 21.

Original Communications.

MINNESOTA AS A RESORT IN PULMONARY AFFECTIONS.

By B. F. D. Adams, M.D., Waltham.

Minnesota occupies nearly the geographical centre of the North American continent, lying midway between the Atlantic and Pacific Oceans, Hudson's Bay and the Gulf of Mexico.

The State embraces an area of about 84,000 square miles, a territory much greater in extent than that of all the New England States combined.

The general surface of the country is undulating, having its greatest depression at the junction of the Mississippi and Minnesota rivers, in the immediate vicinity of St. Paul, and from this point, 850 feet above the level of the sea, it gradually rises, on the south, to a general average of 1000 feet near the Iowa line, and on the north, to the highlands of Minnesota. These highlands, some 1600 or 1700 feet above tide water, form the summit of the great watershed of the continent, sending its waters northward through the Red river to Hudson's Bay, eastward through the Great Lakes and the St. Lawrence to the Atlantic, and southward through the Mississippi to the Gulf.

The climate of Minnesota and of a vast region lying to the northwest of it, is peculiar, differing widely from that of any other part of the country. Perhaps its most striking characteristic is the great difference in the mean temperature of the summer and winter months, that of summer being, at St. Paul, as high as 70°6, while that of winter is but 16°1.

This is forcibly illustrated by a comparison with eastern points. In St. Paul the average temperature for the whole year, as drawn from the records of Fort Snelling, five miles from the city, is 44°5. This coincides nearly with that of northern New York, northern Vermont, central New Hampshire, and southern Maine. Its spring temperature 45°6 is the same as that of central New York and southern Connecticut. Its summer average of 70°6 finds its equivalent in central Pennsylvania, New Jersey and New York city. Its autumn temperature 45°9 is that of northern New York, while its equivalent in winter 16°1 is only to be found in the northern extremity of Maine. Thus we find the summers of central Pennsylvania and New Jersey succeeding the cold of our most northern New England winter.

There is a similar and equally marked contrast of winter and summer extremes in the amount of rainfall of this region.

This is shown in the following table taken from the report of the Commissioner of Statistics for 1860–61, in which the mean temperature and rainfall of each succeeding month is placed side by side.

	Winter.			Spring.			Summer.			Autumn.		
	December.	January.	February.	March.	April.	May.	June.	July.	August.	September.	October.	November.
Mean temperature.	16°9	13°7	17°6	31°4	46°3	59°	68°4	73°4	70°1	58°9	47°1	31°7
Rain—inches.	0·7	0·7	0·5	1·3	2·1	3·2	3·6	4·1	3·2	3·3	1·4	1·3

This synopsis shows one or two curious facts—The small amount of rainfall in winter (it being understood that snow is measured as rain in the proportion of 12 to 1), its evenness of distribution through the three months as compared with the evenness of temperature, the abrupt transition from winter to spring, with the corresponding increase of rainfall, and the rapid rise of heat and moisture from this point, culminating at midsummer, and then declining through the same regular gradations.

In the absence of any accurate hygrometrical records, we get from this table the best indication I can give of another prominent peculiarity of the Minnesota climate, the great dryness of the atmosphere during the colder months.

Owing to the uniformly low temperature of winter, thaws to any extent seldom occur, and rain very rarely falls, so that the ground generally remains covered from the first snowfall to the final thaw.

Remembering the difference in the conducting powers of dry and moist air, the effect of this uniform dryness in mitigating the severity of the cold will be seen at once. With the slight rainfall, too, comes the long succession of bright, sunny days, which form the especial charm of these winters, and are of such inestimable value to the invalid seeking an out-door life.

To this dryness of the atmosphere, more than to anything else, Minnesota owes its deserved reputation as a resort in pulmonary affections.

The moisture of the summer months, however, as marked by the rainfall, is quite equal to that of our New England States, and as the heat is much greater, it is not generally wise to send patients there before the early autumn. We can find on the higher table lands of our New Hampshire hills, or on the western slope of the Green Mountains, a much better summer climate.

The problem of a choice of climate for our phthisical patients is often an extremely difficult one, our decision being guided as much by questions not strictly medical, and by the constitutional idiosyncrasies of the individual, as by the actual pathological condition developed by the stethoscope. There is no specific influence in any climate, but, with certain exceptions, the cold and dry, such as we have in its greatest perfection in Minnesota, usually produces the best results, mainly because under its influence digestion and nutrition are most likely to improve, provided only the patient has sufficient vitality to thoroughly react from exposure to cold.

In those cases of phthisis, however, in which acute inflammatory symptoms are of frequent occurrence, or in which bronchitis exists largely out of proportion to the amount of local lesion, the dry, bracing quality of the air is too stimulating, and seems to act as a decided irritant.

In a letter recently received from my friend Dr. Flagg, of St. Paul, a gentleman in whose judgment and accuracy I have the greatest confidence, and whose opportunities for observation during a practice there of several years have been very considerable, he has expressed so well and concisely, opinions which my experience during a two years' residence in Minnesota entirely confirm, that I cannot resist quoting largely from it, though it was not intended for publication. He says:

"The class of phthisical patients most likely to be benefited by the climate of the Northwest, is the purely tuberculous, those in whom cachectic symptoms are early noticeable, and in whom the lesion of the lungs originates in tuberculous diathesis, rather than in some one of the inflammatory processes sketched by Virchow, Niemeyer and other of the German pathologists. * * * * Tuberculosis being dependent on a constitutional cause, and being a disease of nutrition, is likely to be benefited by the increased energy of circulation and cutaneous function, and the improved assimilation effected by residing in a cold dry climate, as this is, compared with more southern and eastern parts of the country. I am inclined to ascribe pretty much all the benefit I have seen obtained here to improved assimilation, which my observation of patients under my charge convinces me does take place. Of course something is due to change of habits, to the effect of new scenes and society, and to rest from business, and should be placed to the credit of travel as much as to any special effect of climate.

"The pre-tubercular stage as described by E. Smith, of Brompton Hospital, indicates the class which is best suited to Minnesota. Persons of what is described as lymphatic temperament, and those in whom hæmoptysis has been an early and prominent symptom, are especially adapted to this climate, also those vaguely, yet perhaps expressively described as 'relaxed,' showing want of 'tone' of mucous surfaces. Those in advanced stages of phthisis should not expect benefit, and often derive positive harm. The existence of a cavity of any extent, with pus producing surface, should prevent a patient coming here.

"The amount of lung consolidated is not an objection, unless the health is proportionately impaired. I cannot be too plain in advising that patients in whose lungs there is a large deposit of tubercle rapidly undergoing softening, should not be sent. The existence of small cavities, the morbid process being quiescent, is not an objection. It is rather the active inflammatory process consecutive to deposit and softening of tubercle, that is more likely to receive harm than good. Those who are subject to intercurrent attacks of bronchitis, or who suffer from a sense of 'constriction,' to use a patient's term, during cold, dry winds, are not very suitable cases.

"There is a distinction between bronchial complications. Those who have deficient expectoration (bronchial), that loud, dry, ringing cough, dry ronchi, and who readily develope an acute attack, with considerable fever, or perhaps nervous symptoms, are not likely to improve in this climate. On the contrary, those who have congested mucous membranes, the throat perhaps looking sodden, *not* red, fiery and dry, a good deal of morning expectoration, and perhaps a sluggish circulation, will generally do well.

"In short, those who are markedly prone to local inflammatory attacks are not very suitable cases to send in winter. They do pretty well in the summer, but what I have written applies more especially to the winter, that being the season selected by invalids, our summers not differing sufficiently from the eastern climate to offer any inducement for exile.

"Other forms of phthisis, those in which the disease is chronic pneumonia, the unabsorbed pneumonic deposit of Andrew Clark, the lung lesions following acute pleurisy and pneumonia, do well or otherwise as the general health is markedly disordered or not.

"Of course in such cases one of the principal objects of treatment is to maintain the general health, and in many cases I have seen nutrition and circulation improve and corresponding improvement in local lesions, yet as a rule I think such cases do better in a warm and dry climate."

I have nothing to add to this admirable summary of Dr. Flagg's.

We see Minnesota is not the sanitary Utopia, which some of its friends would have us believe, though for a certain class of cases perhaps no place presents equal advantages. I need not remind the profession of the large number of diseases other than phthisis in which we may expect improvement under the influence of so bracing and tonic an atmosphere. All who have experienced the new life and vigor which our clear cold northwest winds bring with them, can appreciate the effect of the Minnesota climate on those who can resist the severity of its winters.

It remains to speak of a few things of interest to those about to remove to the west. Agriculture is of course the chief industry of the State, but labor of any kind, particularly skilled labor, will usually command a market. The professions, as in the west generally, are over-crowded, and those seeking employment in the mercantile houses of the larger cities might at first experience some difficulty in finding it, unless they commanded capital.

The hotels and boarding-houses of the two principal places, St. Paul and Minneapolis, are better than we should find in towns of the same size in the East, though they do not compare favorably with the larger houses of New York or Boston.

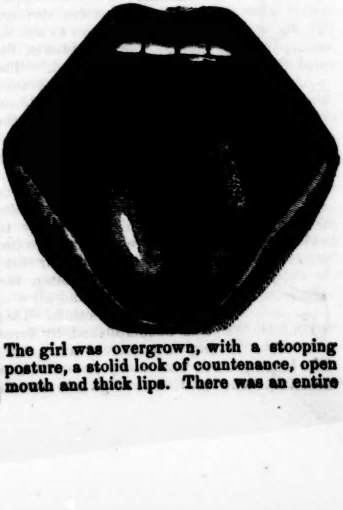
The price of board is about the same there as here, for the same accommodations. The markets are excellent, being constantly supplied with a variety of game, besides all the ordinary meats of very good quality. The price of all provisions, except those brought from the East, is very much less than with us, considerably reducing the cost of housekeeping.

NASO-PHARYNGEAL POLYPUS REMOVED THROUGH THE MOUTH BY A MODIFIED ECRASEUR.

By Ephraim Cutter, M.D. Read before the Suffolk District Medical Society, Sept. 24th, 1870.

In October, 1869, the mother of M. T., æt. 15 years, consulted me in relation to her daughter's eyes. According to the best of my judgment, there existed severe corneitis and conjunctivitis. I sent her to the City Hospital, where she came under the care of Dr. Williams. Afterwards, the mother stated that the eyes were not much improved, and desired me to look into her daughter's throat to see why she made so much noise with her breathing at night.

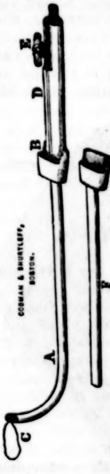
Fig. 1.



The girl was overgrown, with a stooping posture, a stolid look of countenance, open mouth and thick lips. There was an entire absence of the vigorous, intelligent and active look of a girl of similar age. On looking into the mouth and depressing the tongue, I saw a fleshy mass behind the soft palate, entirely filling the space between the pillars and reaching down to the level of the tongue. Whilst I was looking, the patient gagged several times, when suddenly from beneath the left pillar of the soft palate a cylindrical polypus protruded and reached two thirds the length of the tongue. It resembled a boy's penis in a state of erection. Vide Fig. 1.

The polypi evidently were pedunculated and attached somewhere in the naso-pharyngeal space. The problem was to remove them, cutting their base *in situ naturali*, without disturbing the normal tissues. The operation was performed, Nov. 11th, 1869, in the presence of several physicians, thus:—A No. 12 annealed iron wire, three feet long, was bent double. The two ends were given one to one assistant, the other to another, with instructions not to allow any twisting. The loop was slightly bent downwards, and then passed through over the floor of the right nostril (which had been found more pervious than its fellow) into the mouth. It was then drawn forwards in front of the tumors, the loop expanded and then pushed backwards behind the growths. Traction was made by the assistants on the free ends of the wire, and then a flattened brass tube (Fig. 2), 6 inches long, $\frac{3}{16}$ of an inch wide, $\frac{1}{16}$ of an inch thick, inside measure, was slipped over the two wires through the nose down on to the tumors. The flat sides of the tube were vertical. The proximal end of the tube was provided with a brass thimble, soldered on to the end in such a manner as that the tube rested against the thimble, and the opening of the tube corresponded with a similar one in the thimble. It was only necessary to slip the wedge-shape extremity of the écraseur into the thimble and fasten the wire to the nut, and all was ready for the section. This was accomplished by turning the screw as usual. The large growth was easily cut off. The assistant who held it through the mouth lost his hold, and it was swallowed!

FIG. 2.



It remained to cut off the cylindrical polyp. This was done through the mouth as follows. A brass tube, similar to that just described, was bent up at the distal end to a curve of a quarter of a circle. (Fig. 2.) The wire, well greased with lard, was run through, leaving a loop large enough to slip over the growth. This loop was bent outwards to a right angle with the end of the écraseur tube. The tube was attached to the écraseur and the wire fastened as before. The loop was passed over the polyp up behind the soft palate, until the horizontal portion of the tube rested against the under edge of the soft palate. Traction was made upon the growth, and a few turns of the screw cut it off. This was not swallowed.

A marked improvement followed; the breathing was free, and the inflamed eyes got well very soon, showing a seeming connection with the presence of the growths.

In June, 1870, I discovered that the larger growth had returned, although its removal had been accomplished by a transverse section through its substance, the écraseur wire cutting in the direction of the long axis of the écraseur. Still, as the growth had a higher origin than opposite the floor of the nostril, it was evident that the section was not made high enough. Moreover, it was also plain that no higher cut could be made through the nose. Remarking that the smaller growth had not returned, and that although the loop was bent to a right angle over the end of the écraseur, still the section was accomplished more thoroughly, I proceeded to remove the recurred growth July 14th, 1870, through the mouth, and speedily accomplished it in the same manner as the smaller growth at the first operation, except that after having passed the loop over, I seized the growth with my left thumb and finger, drawing it down and raising the écraseur up. Thus the section was made as close as possible to the origin. Indeed, the rhinoscope afterwards showed the seat of insertion to be on the median line of the post-pharyngeal wall, well up towards the dome. It was cleanly cut off, as with a knife. It was touched with stick nitrate of silver, and has not returned. At the present time the patient is doing well.

Remarks.—This modification of écraseur can be adapted to the larger forms of instruments. It may be soldered to a nut which may screw into the shaft of the instrument. The main features of it are simplicity, minimum amount of material, and strength. When operations are conducted in cavities of limited size, it is necessary to have the instruments as much smaller than the cavity as is possible and yet strong; if the cavity cannot be enlarged, the instrument must be diminished. In the case of the common nasal polypi I have found this modification work well and painlessly. By using the curved instrument, the operator can see to pass the loop up under the growth, while an assistant cuts it off. In relation to strength, the instrument stood a severe test in a case of intra-uterine fibroid, an account of which will probably appear elsewhere. In this instance it was found, after an hour and a half hard work by one of the most accomplished of operators, impossible to surround the growth with a chain. However, the compact tube and wire were carried into the uterus, the loop spread and pushed up round the fibroid by the fingers and a blunt probe. The growth was cut off with no difficulty. A second cut was rendered necessary, by the same means, before a portion was removed. The remaining moities were extracted by forceps, very much as a child is delivered. The growths were dense and tough, yet the tube écraseur cut through them.

DEFECTS OF OCULAR REFRACTION, &c.

(Continued from page 310.)

Lecture III. Part I.—*Three Principal States of Refraction and their Diagnosis.*

We have seen that by the expression *refraction* of an eye is meant that state in which its refractive power is at a minimum, and in which it is adapted for its far-point; and in which also the accommodation is null (if we suppose that there is no negative accommodation, that is no muscular contraction causing a diminution of refractive power).

States of refraction have been divided into three principal classes, according to the position of the far-point.

1st. *Emmetropia*, in which the far-point corresponds to parallel rays and is at an infinite distance in front of the eye.

2d. *Myopia*, in which the far-point corresponds to diverging rays, and is at a finite distance in front of the eye.

3d. *Hypermetropia*, in which the far-point corresponds to rays already converging, and may be considered to be at a finite distance *behind* the eye.

It is also to be noticed that in emmetropia the principal focus or focus of parallel rays is at the retina; in myopia the focus of parallel rays is in front of the retina, so that diverging rays are required in order that their focus may be at the retina; and in hypermetropia the focus for parallel rays is behind the retina, so that rays already converging are required in order that their focus may be at the retina.

The difference in the far-point is thought to be generally due to a difference in the length of the eye, measured antero-posteriorly from near the middle of the cornea to the macula lutea, rather than to a difference in the refractive power of the system of cornea and lens, the myopic eye having been found longer than the emmetropic, and the hypermetropic shorter.

But in astigmatism, in which the refractive power is different in the same eye in different planes passing through the antero-posterior axis, this difference must lie in the refractive apparatus proper; and in such case the myopic meridian is stronger, more refractive than the emmetropic, because it requires more refractive power to bend diverging rays to a focus on the retina than to bend parallel rays to the same focus. Similarly, the hypermetropic meridian is weaker, less refractive than the emmetropic. Bearing in mind that a concave glass diminishes the refractive power, and that a convex increases it, it may be said that the strongest meridian in astigmatism requires less artificial *addition* to its refractive power than the weakest.

We may, also, even when comparing together different eyes, consider the myopic eye as relatively more refractive than the emmetropic; relatively to the object to be attained, the bringing of the rays from a point at a given distance in front of the respective eye to a focus on its retina, and looking to the strength of the glasses to be required for this purpose.

Supposing both eyes adapted for their respective far-points, an eye with myopia $\frac{1}{10}$ requires no glass to see at 10 inches, while an emmetropic eye to see at this distance would require a convex glass $\frac{1}{10}$; that is, is relatively weaker than the myopic eye by the amount of the myopia.

Also, in the same circumstances a hypermetropic eye would require a convex glass $\frac{1}{10}$ and in addition the glass to correct the hypermetropia; that is, is relatively weaker than the emmetropic by the amount of the hypermetropia.

It may be noticed that eyes not emmetropic are included under the term *ametropic.*

In investigating any case which presents itself for treatment, we must determine the far-point, because the presence of myopia, or of hypermetropia, would furnish important elements to be considered in the diagnosis and treatment. The far-point may be determined by trying the patient's vision with glasses, or by examining the eye with the ophthalmoscope. In using the former method it is to be remembered that the far-point corresponds to the minimum of refractive power.

Hence the rule, to find the strongest convex or weakest concave which gives the best vision for distant objects. The eye will then be reduced to its minimum of refractive power, because seeing through the glass of the most power (the glass and the eye together being just equal to the power required to bend parallel rays to a focus on the retina). The eye will then be adapted for the rays which emerge from the glass; this we know, because the vision is at its maximum. The point of origin of these rays is the far-point.

We thus learn that the eye, when reduced to its minimum of refractive power, is adapted for certain rays—those which emerge from the auxiliary lens, and from which the far-point is easily inferred. That the eye is so adapted appears from the fact that, with these rays entering it, vision is at its maximum.

To test the acuteness of vision we make use of letters of different sizes. We seek the strongest convex or weakest concave which gives the maximum of vision. Of several convex glasses giving equally good and the maximum vision, we select the strongest for the determination of the far-point; and of several concaves, the weakest.

In testing the vision with glasses to determine the far-point, the ocular media are supposed clear, otherwise irregular refraction may interfere with the definiteness of the result.

The accommodation is also supposed to be reduced to zero; this state is promoted by letting the patient look at *distant* test objects; also by trying successively stronger and stronger convex glasses till the strongest are found with which the maximum of vision is obtainable, or by trying weaker and weaker concave, till the weakest are found with which the maximum of vision is obtainable.

The accommodation might be paralyzed by applying the sulphate of atropia to the conjunctiva, but the result—the dazzling and inability to see near objects distinctly—inconveniences and often alarms the patient. It may also be mentioned that atropine has been thought by some or suspected to have induced attacks of glaucoma in eyes previously disposed to it.

Bearing in mind the above, suppose that an eye sees distant objects *better* with no glass than with any convex, and *as well* as with any concave; if the vision is proportional to the age of the patient (it being remembered that the acuteness of vision diminishes with years), the eye is then *emmetropic*. If the vision is less than normal to the age of the patient, we must look for some cause not remediable by spherical glasses, such as astigmatism or disease of the internal membranes, &c. Opacities of the media are supposed absent. For such investigation recourse must be had to the ophthalmoscope, by means of which we may also obtain independent information as regards the refraction.

Again, if the eye sees distant objects best through a convex lens, and if vision is normal, then the eye is hypermetropic. If vision is not normal, we must look as before for the cause. If the eye has sufficient accommodation to neutralize the hypermetropia, the vision with the convex may not measure more than without it; but if it measures as much, and if it is normal, we infer hypermetropia.

If an eye without opacities of the media, and with its accommodation inactive, sees distant objects *better* with a concave than without, myopia exists. Opacities of the media often exist together with myopia, in which cases, if the opacities do not prevent, we may determine the refraction by the ophthalmoscope. We shall see, later, that an eye *with opacities of the media* might see better in the distance with a concave and yet not be myopic.

We measure the vision by the smallest objects which the eye with perfect adjustment can see in the distance. These might be different for different eyes and for the same eye at different times. It is therefore desirable to have some standard objects with which to test the acuteness of vision.

It is found that an eye of normal visual acuteness can distinguish letters subtending a certain angle and separated by an interval of the same amount. The letters of Snellen, at the distances which designate them, subtend each an angle of 5 minutes, the separate strokes subtending in breadth an angle of 1 minute. By increasing the size of the letter proportionally to its distance from the eye, the retinal image will remain very nearly the same.

Snellen's letters marked C C are ten times as large as the X X. The letters are in size proportional to the distances designating them and at which a normal eye, accommodated for the respective distance, is able to see them distinctly. If D is the greatest distance at which a normal eye can see certain letters distinctly, and if another eye must approach nearer to the distance *d*, in order to see them distinctly, the vision of the latter eye is to unity as *d* is to D. Or, if an eye at twenty feet cannot see smaller letters than X L, then we may say roughly (supposing that it could not see the letters X L farther off than twenty feet), that its vision is to unity as 20 is to 40, that is, as the greatest distance at which it can see the letters is to the distance at which it should normally be able to see them.

The acuteness of vision varies with the light. Artificial light has been recommended as admitting of more uniformity; and, if less intense than bright daylight, it would allow the pupils to dilate more and so render more manifest any defective adjustment, as this latter is to a degree remedied by a narrow pupil.

The acuteness of vision diminishes with advancing years. At forty years it begins to sink rapidly, about as follows: at fifty years having diminished about one-fifth of its whole amount; at sixty years, one-third; and at eighty years, one half.

With regard to the determination of the far-point by the ophthalmoscope, it must be remembered that there are two methods of ophthalmoscopic examination, that of the upright and that of the inverted image. The process in the upright is as follows: a point of the fundus oculi illuminated by light reflected from the ophthalmoscopic mirror into the eye, sends out rays again through the ocular media into the air. Arrived in the air, they will have directions such, that if they were considered as passing into the eye instead of leaving it, they would come to a focus at the same point from which they started. These directions, then, if we suppose the accommodation inactive, will depend on the particular refraction of the eye under examination. They will be parallel if the eye in question is emmetropic; they will be convergent towards the observer if the eye is myopic, and divergent if it is hypermetropic.

If the observer's eye is emmetropic, and adapted for its far-point, he will see distinctly without assistance of any glass a picture of a point of the retina of the observed eye, if the latter is also emmetropic and adapted for its far-point. If we suppose several points of the retina or fundus oculi under observation to have sent out rays, as is the case, the observer will see an upright picture of them; the point which is above will appear above.

If on the other hand the eye to be examined were myopic, the rays from the fundus would, when arrived in the air, converge to a point at a definite distance in front of the eye. The supposed emmetropic and non-accommodating observer, if near to the patient, between the patient's eye and the point to which the rays converge, is not then adapted for the converging rays; but with the assistance of an appropriate concave glass, he would be; and an upright image might be seen as before.

If, again, we had to do with hypermetropia, the rays from a point of the fundus would, when arrived in the air, be diverging towards the observer; and the emmetropic observer would not be adapted for these diverging rays, except by accommodating, or by the aid of an appropriate convex glass.

Therefore, if we suppose the eye in question to exert no accommodation, we can infer it to be emmetropic, myopic, or hypermetropic, respectively, according as the emmetropic observer accommodated for parallel rays requires in order to see distinctly the upright image no glass, a concave or a convex. The strength of the glass and its position indicate the far point.

If the observer or patient should accommodate during the examination, it is equivalent to an alteration of refraction. If the observer is ametropic, we can suppose his ametropia corrected by a glass. The details of the corresponding changes in the examination can be understood with some attention, and have recently been described by Dr. Loring in English, and by Dr. Mauthner in German.

Another means of recognizing a *high degree* of myopia consists in using simply a mirror, perforated, or with the central part uncoated, and at a greater distance from the patient than his far-point; then we get an inverted image of a portion of the fundus, the image being formed in the air, in front of the eye, at the distance of the far-point, supposing the accommodation inactive. If the observer then moves *to the right*, the image seen seems to move *to the left*; whereas, if the eye to be observed were hypermetropic, the picture seen under similar circumstances would be upright, and would seem to move *in the same direction* as the observer moves (to the right, or the left, up, or down).

Reports of Medical Societies.

BOSTON SOCIETY FOR MEDICAL IMPROVEMENT.

CHARLES D. HOMANS, M.D., SECRETARY.

AUG. 8th.—*Enlarged and Hypertrophied Stomach; Contracted Duodenum.*—Dr. G. C. SHATTUCK reported the case.

The patient was a woman, 65 years old, symptoms of disease having existed for several years. Four years ago, she vomited a considerable quantity of blood, and afterwards had no very severe symptoms till December, 1869, though she had been three times during the interval in the Samaritan Hospital, for cough, irritable stomach, &c. Since the last date she has had, at times, attacks of vomiting, very severe in April, 1870, and since then occurring more or less nearly every day; she was in the City Hospital for a few weeks this summer, and finally entered the Samaritan Hospital July 8th, and died there, Aug. 3d, from inanition. There was considerable epigastric pain and tenderness at times in the right hypochondrium; the bowels were constipated; the matter vomited consisted of ingesta, watery fluid and chocolate-colored liquid in varying quantities, sometimes a quart at once.

The stomach was enlarged and its walls much hypertrophied. The pyloric orifice was very greatly dilated ("béante"), and two fingers' breadth beyond was an annular and extreme contraction of the duodenum, the passage through the intestine at this point being only about one fourth of an inch in diameter. The large intestine was closely adherent to the duodenum, and in the interior was an apparent loss of substance corresponding to the adhesion, as if ulceration were taking place as a preparation for perforation.

Dr. JACKSON thought that the contraction of the duodenum might have been the result of a chronic ulcer, to which this portion of the intestine is liable; and he referred to a case of ulcer at the pylorus, in which the contraction was as great or even greater—the distention of the stomach being perfectly enormous. The condition of the large intestine he especially remarked upon. When preparations are being made, in the course of disease, for an opening into a cavity that is lined by a mucous membrane, ulceration or a destruction of the tissues takes place upon the diseased surface, and at a properly selected point; and, sooner or later, a similar process is not unfrequently set up upon the mucous surface, and at a corresponding point. Dr. J. has seen cases of this sort where there was disease of the gall bladder or ducts, and nature has evidently intended to effect an opening into some portion of the alimentary canal. In Dr. Shattuck's case, the duodenum was nearly closed; and, as the chyme could be got rid of, mainly, in no other way, it was to be carried directly into the large intestine. In thoracic aneurism, Dr. J. has several times seen ulceration upon the inner surface of the œsophagus or intestines, and corresponding to the nearest point of the diseased cavity; though what object nature could have in setting up a process that, when completed, would result in the immediate death of the patient, can hardly be imagined. Cruveilhier figures such a case; but Dr. J. knows of no author who has made any general remarks upon the above pathological fact.

Dr. KNIGHT thought this occurrence might nearly always be explained by some interruption or other modification of the nutrition of the part, as in the case of aneurism, by pressure; this he thought a more philosophical explanation.

Dr. JOHN HOMANS agreed with Dr. Jackson; he considered it a remarkable instance of intelligence in nature.

To Dr. LANGMAID Dr. Jackson said, the thickening sometimes noticed about these ulcers consisted of a thickening of the ordinary tissues and of the cellular tissue outside, as in any condition of chronic inflammation. He thought ulcer of the stomach was not specific in any way, merely an ulcer which selects for some unknown reason a certain portion of the stomach and small intestine.

AUG. 22d—*Deformity in the Fœtus, apparently produced by Mental Impression on the Mother.*—Dr. MINOT reported the case.

A respectable married woman, early in her second pregnancy, while riding in a street car, observed a man, sitting opposite, who had lost all the fingers of one of his hands. She afterwards related the circumstance to a lady (who reported the facts to Dr. Minot), saying she feared her child would be deformed. The child, born at the full period, and healthy, had no fingers on one of its hands, the thumb alone being perfect, thus exactly resembling the mutilated hand the mother had seen.

AUG. 22d.—*Letter from Bagnères de Bigorre and Cauterets.*—Dr. MINOT read the following extracts from a letter from Dr. JEREMIAH WHIPPLE, of Boston, giving an account of Bigorre, and of the mineral waters of Cauterets, in the Pyrenees, places much resorted to by invalids with affections of the chest and other diseases:

"I went in June to Cauterets, about 40 miles from Pau, where I took the waters and baths for nearly a month. While there, I studied their effects on various diseases, as closely as I could. I had occasion to know intimately some cases, and more or less of a good many others, and I am convinced that the waters, applied with judgment, may be of the very greatest benefit, especially in many cases of pulmonary disease. In my own case [pleurisy], their effect was certainly excellent, and every case I saw was more or less benefited.

"The waters are alkaline and sulphurous, varying in temperature from 20° to 53°, Centigrade (68° to 127°4, Fahrenheit), and different springs seem to suit different cases, even of the same diseases. Before I had taken the waters ten days, I did what I had not done since December—slept equally well on both sides; and, for the first time in six months, had an appetite for my dinner, and was able to walk to *my* spring, a mile and a half, up hill, without being used up for all day.

"I have seen the effects of these waters on other cases of pleurisy, and on many cases of different stages of tuberculosis. The effect of a judicious course of the waters seems to be to aid very materially in breaking down the old adhesions, and absorbing the morbid thickening of the membranes, in the first disease, and helping to cicatrize cavities in advanced cases of the second, and of producing some effect in early cases, which certainly improves the respiration, and equally certainly is of great general advantage. That the waters have a great reputation you will judge from the fact that, through the months of July and August, there are often 5000, and on the average 4000 people in a little town where there are but 1100 *indigènes*, and where the only attraction beyond a few days is the water. That they do all that those whose interest it is to 'write them up' claim, is, of course, absolutely false. That they do very serious harm, if applied to the wrong cases, or if given without fixed rules, is certainly true. I saw one or two cases of brisk hæmoptysis from taking them after very recent congestion, and from my own experience I found that an over-dose made mischief at once. I knew what I was about, and only took over-doses as experiments. I risked two tumblers at one time, and found the whole world growing black, and my sight leaving me within half an hour, and my nose (*only* the nose, fortunately), bleeding briskly. A foot-bath at full temperature for half an hour set me right again, and after a second trial I thought I knew what I wanted in regard to the strength of the water. This, however, was the strongest spring, and I found myself more susceptible than usual to the effects of the water. A full glass, however, at a time, is considered the maximum dose—this repeated two or three times a day.

"The benefit in some cases that I have seen, of whose previous history I knew something already, has been most marked and gratifying. Notwithstanding what I had heard of them, I had but little confidence that the waters deserved a tithe of what is claimed for them; but my own experience, and as close observation as I could give for a month to their effects, have very much modified my opinion, and I shall follow the cases with which I have become acquainted with the greatest interest.

"Cauterets, I should say, is too high [3254 feet above the sea] for most cases of advanced phthisis, and scarcely suitable for any except during the months of July and August. It is a beautiful spot, but, aside from the beauty of its scenery, does not offer much in the way of pleasant distraction. It is surrounded on all sides by very high mountains, and the basin in which it is situated is in no place more than from a quarter of a mile to half a mile wide. From its height and situation the change from noonday temperature to that of the evening and night is very great. After passing the middle of the day in as little clothing as the law would be content with, one is always glad of an overcoat at night, and in case of a storm a fire becomes a necessity. You will see how much care would be requisite to guard against such changes for a long time, and how few would be willing to take that care. As for myself, I felt better from the moment I arrived there, as I always do in a higher region; and being rendered, as all are, very sensitive to changes of temperature by the use of the waters, which act largely on the skin, I never stirred, scarcely even at noonday, without an overcoat, and so escaped colds. In regard to the waters, I repeat, I am more and more convinced of their efficacy, as I watch my own case and several others which have been all summer under my eye.

"We are now [July 24th] settled in Bigorre [elevation, 1760 feet above the sea], just in the edge of the Pyrenees, where we have full benefit of the delicious mountain air, and cool evening breeze which invariably follows the rather warm day. Our balcony overlooks a number of pretty gardens, with the Pyrenees just beyond, which look cool and comfortable even in the hottest days. In the daytime the mercury often ranges from 80° to 90° Fahrenheit, but one would never imagine it without consulting the thermometer, for the heat is perfectly dry, and the air never dead or oppressive. The heat here does not seem, either, to provoke the excessive thirst which we feel in our summer weather at home. The evenings and nights are invariably cool, and for the most part perfectly dry, so that one can enjoy the freshness without danger. This place is a favorite summer residence for many who pass their winters at Pau, or along the Mediterranean. There are many who pass the whole year here, for, though lacking many of the advantages of Pau, yet the winter is comparatively mild, and at that season the living, especially in the item of rent, is very cheap. It is, I should say, about the best summer climate possible, not only for invalids, but for every body else. The place is dull, to be sure, doubly dull in these times of war; yet there is enough going on to keep one awake most of the day, and quite enough for any place the resort of invalids. But if it is dull, it is pretty, and the air, though often hot, is never, or almost never, enervating. The neighborhood of the mountains keeps it fresh and changing. I have seen the mercury higher than 80° only once for a few hours, when everyone called the day unusually hot, though I suffered no inconvenience, as the air was perfectly dry."

Oct. 24th.—*Epidermic Engrafting.*—Dr. Porter gave a brief history of this new process, and exhibited a patient on whom he had done the operation.

The operation is one first introduced by M. Reverdin, an *interne* in one of the Paris hospitals, for promoting the healing of ulcerated surfaces by engrafting upon them small pieces of healthy epidermis. The operation consists in cutting from any part of the healthy skin, with the knife or scissors, small pieces of epidermis, implicating as little as possible the vascular layer of the skin, and planting these in small incisions made in the granulations and strapping them into place by adhesive plaster. After a few days, varying from seven (7) to fourteen (14), if the engraftings are successful, small islands of epidermis appear, which increase in every direction, and thus materially diminish the time which would otherwise be required for the healing of such surfaces, and in all probability the contraction which results from cicatrization of large granulating surfaces. The first reported case which I can find is one by M. Sée, reported at the Imperial Society of Surgery at Paris, June 1st, 1870, and published in the *Gazette Hebdomadaire* July 22; another, in the *Lancet* July 9th, a case by Mr. Pollock, of St. George's Hospital, London. The case which I have to present to the Society to-night does not, I am aware, fully illustrate all that may be claimed for the operation, as it is one of varicose ulcer of the leg, which would have probably quickly recovered under proper treatment without the engrafting; but it does prove—and this is the point to which I would especially call the attention of the Society, what, so far as I am able to learn, has not been tried before, viz.—*that these engraftings can be made successfully upon ulcers of the lower extremity, and the patient allowed to walk about and work during the process of healing.* Before giving the history of the case, I would mention one exceedingly interesting fact connected with the new growth, mentioned to me by Mr. Pollock, that for some weeks there is no sensation, but after that time this is gradually established, apparently showing that at first there is a want of nervous supply to the new growth.

The patient was a man, aged 56 years; he had an ulcer of three months' duration on the internal aspect of the leg, a little above the malleolus, 3 inches by 2 inches in size, and a varicose condition of the leg. Oct. 4th.—Two small pieces of skin were inserted and strapped into place. Oct. 7th.—Strap removed, and no appearance of pieces. Oct. 11th.—Strap removed; one small island appearing, twice as large as the head of a pin. Ulcer healing from edges. Oct. 14th.—The small island has extended, and has bridged a third of the transverse diameter of the ulcer. Patient states that he does his regular work every day. Oct. 18th.—The ulcer still healing from the edges, and the island is no longer an island, there being a strong bridge of skin uniting it to the outside edge of the ulcer. Oct. 24th.—The ulcer is almost completely bridged across and still healing from edges.

Dr. Coolidge also exhibited a patient on whom he had tried this method of inducing cicatrization. The man had suffered for twenty years from ulcers of the leg, which had healed under proper treatment and broke out again. When he entered the Massachusetts General Hospital, there was one extensive ulcer occupying a large part of the anterior surface of the leg above the ankle; under proper treatment this diminished in size, leaving an ulcer six inches by four, which would not heal, and for the last six weeks, though the patient was confined to bed, no improvement had taken place. Oct. 2d, Dr. Coolidge applied a blister to the sound skin, and just before it had risen punctured some small vesicles and drew the epidermis from off the rete mucosum; then, by means of a small forceps pincing the raw surface up, he removed a layer comprising all the rete mucosum and engrafted it into one of the granulations of the ulcer; he also, with his scalpel, scraped the surface of the blister and spread upon the ulcer the cells which were immediately over the papillæ and cutis. This operation was performed ten to twelve times and the ulcer immediately strapped; the plaster was not removed for ten days, when a few doubtful spots were seen on the surface of the ulcer, which had considerably diminished in size. It was again strapped, and ten days afterwards—twenty days after the last operation—the plaster was again removed, and there was seen an undoubted island of new epidermis in the middle of the ulcer, and several white spots in the new skin surrounding it, which he considered to be the other engrafted points.

Oct. 24th.—*Suppuration of the Frontal Sinus.*—Dr. Hodges reported the case. It occurred in a man, 48 years old, and had commenced, without known cause, fourteen years ago. The accompanying pain in the forehead had been intense at times, and was always relieved by a discharge of pus from the nostril. About eight years ago, a fluctuating swelling formed over the sinus, beneath the integument of the forehead, and this was punctured with a lancet a few months before the patient was seen by Dr. H. Pus was evacuated, and the swelling, which persisted, had continued to discharge ever since. On laying the abscess freely open, a single small orifice, through the frontal bone, communicated with the cavity of the sinus. The sinus was trephined and found to contain a large amount of very offensive pus. No necrosed bone was detected. The operation was followed by great relief. Dr. Hodges spoke of the rarity of this affection, the occasional presence of air in the frontal tumor, and the possibility of the inflamed sinus opening into the cavity of the cranium, or exciting inflammation of the meninges of the brain.

Dentigerous Cyst.—Dr. Hodges exhibited two teeth, a canine and a bicuspid, removed from a dentigerous cyst, which had developed at the side of the lower maxilla, in a boy ten years old. The cyst had been but four months in forming. The external wall, which was thin and parchment like, on being excised permitted the easy extraction of the misplaced teeth. Dr. Hodges remarked that this was the third specimen of this somewhat infrequent abnormity which he had exhibited to the Society.

Oct. 24th.—*Restoration of the Membrana Tympani after its almost complete Destruction from chronic Inflammation.*—Dr. J. O. Green, Jr., reported the case.

A man, aged 40, in good health, except marked tendency to nasal catarrh, had suffered from otorrhœa on the right side from childhood, the result of which had been a periostitis of the meatus, which had nearly closed that passage with hyperostoses, and an almost complete loss of hearing on that side. Some eighteen months ago, without any known cause or marked symptoms, the hearing of the left ear, previously good, began to be impaired; he soon became very deaf, and a discharge began from that ear, which continued till August, 1869, when I first saw him.

There was then a small polypus about the size of a pea projecting from the tympanum through a perforation in the posterior part of the membrana tympani, with a purulent discharge. The polypus was removed by the wire snare, and the membrana tympani could be then seen with a large irregular perforation on the posterior segment, and another somewhat smaller one on the anterior segment, the two perforations equal in extent to about one-third of the whole membrane. The remaining membrane was of a dull, pure white throughout, exactly resembling macerated epidermis, and in only one spot, on the edge of one of the perforations, was there the least sign of life.

From that time, although the otorrhœa was gradually checked, the perforations continued to enlarge from week to week, without pain or other symptoms, the membrane slowly melting away. At the end of three months there was only a narrow bridle of membrane running from the end of the manubrium downwards to the periphery and a small triangular portion on each side of the hammer. In three months more this bridle had disappeared, the two perforations had coalesced, and the manubrium lay in position with no membrane on either side of it, the only portion left being on each side of the small process of the hammer. I was unable to discover any of the peripheric portion of the membrane, although the result would show that such must have remained. The mucous membrane of the tympanum was seen to be red, slightly swollen, and from cold it exuded a slight discharge. The Eustachian tube was pervious when the swelling of the mucous membrane was least, and closed when it was extreme. The hearing gradually diminished as the membrane was destroyed, till the raised voice could be heard at only two feet, and the watch only on firm contact.

This condition remained till about three months ago, when I found that a new membrane had begun to form, and this has since progressed steadily till now, as will be seen, there is an almost complete restoration, a perforation the size of a pin-hole only remaining. The new formation sprang from all the edges simultaneously, from the periphery, the edges of the old membrane, and from the sides of the manubrium; it gradually extended, forming a crescent-shaped opening around the manubrium, and this closed to a circular opening, two lines in diameter, just behind the lower end of this bone. Up to this point the new membrane was tense, and exactly in the position and on the plane of the normal membrane; from here, however, the remaining opening seems to be closing with relaxed cicatricial tissue which collapses inwards. The otorrhœa entirely ceased some two months since.

Examination now shows a firm tense membrane occupying the position of the normal membrana tympani; at the upper anterior portion the projecting end of the small process of the hammer is seen, but the manubrium is concealed in the swollen membrane. The periphery of the membrane is grey, as in a thickened membrana tympani, while the tissue more recently formed and surrounding the small perforation is still swollen and slightly red.

Without a microscopic examination, it is impossible to speak of the histological elements of this tissue, but by good illumination I have been able to see fibres radiating from the periphery towards the centre as they are seen in the normal membrane.

The treatment adopted was cauterization of the base of the polypus a few times with the solid nitrate of silver till it had been destroyed, syringing often enough to keep the ear clean, the instillations of various astringent solutions, sulphate of zinc, zinc and alum, sulphate of copper, and the insufflation of powdered alum. During the last few months a solution of sulphate of copper, gr. ij. to the ounce, was used with intermissions and occasionally a few drops of muriate of ammonia, gr. x. to the ounce, was injected through the Eustachian tube by means of the catheter.

The hearing, which had been seriously affected, has greatly improved, but is still somewhat variable, probably owing to a small amount of mucus occasionally clogging the action of the ossicula. A large part of the time he hears "as well as he ever did in his life." When the small remaining perforation heals so as to exclude the outer air, this changeability will probably cease.

The disease was a marked example of chronic inflammation of the membrana tympani, complicated with catarrhal inflammation of the tympanum, as described and figured by Gruber in his Ohrenheilkunde. The case is interesting from the very perfect restoration of the membrane after such extensive destruction, and it is this to which the attention of the Society is called.

OCT. 24th.—*Stricture of the Œsophagus; a small pulmonary cavity surrounded by dense tissue gives rise to a low-pitched blowing respiration.*—Dr. KNIGHT reported the case.

A man, 50 years of age, entered one of the surgical wards of the City Hospital on the 29th of August last, on account of difficulty in swallowing, much of the food being thrown back without reaching the stomach. He said that the difficulty had existed only three weeks.

On the day of his admission, a probang, one and a half inches in circumference, could not be passed with such force as it was thought justifiable to employ. An elastic catheter was passed, however, and the stricture was reported as being about three inches below the thyroid cartilage and moderately tight.

The patient stated that, two years before, he had been bitten on the lip by a man affected with syphilis; that in consequence he had a sore on his lip of several weeks' duration, followed in a short time by a "sore" upon the penis, swelling in the groin, "sores" about the anus, sore throat and falling of hair.

He had no pain in the throat and had never spit up any bloody matter. In the absence of signs of aneurism or other tumor pressing on the œsophagus, the stricture was thought to be due to cancer or syphilis, with a strong inclination to the latter diagnosis, on account of the preceding history. On the 31st, the bougie, one and a half inches in circumference, was passed.

On the 10th of September he was transferred to the medical side, on account of severe, constant cough, which he said had existed three or four weeks. He could then swallow liquids, soft-boiled egg, milk toast and wine jelly.

On Sept. 11th, examination of the chest gave me the following signs:—Relative dulness on percussion in right clavicular region. Considerable bronchial element in the respiratory murmur at right top, front and back, perhaps not enough to be necessarily morbid. Occasional dry bronchial râles throughout chest.

Sept. 25th, examination revealed a marked change in the physical signs at the apex of the right lung. On percussion, there was tympanitic resonance in clavicular and subclavicular regions, cavernous respiration, of low pitch, and bronchophonic voice. On the 26th, respiration was at times stridulous. On the 28th and 29th, swallowed but little if any liquid, and note was made by Mr. Spooner, medical house officer, that "what he took seemed to pass the seat of stricture, but after taking three mouthsful of liquid he regurgitated nearly the whole, if not all of it. Probang passed down throat as readily as usual through the stricture at the upper part of the œsophagus, but was arrested about ten inches from the lips, measured on probang. The patient gradually failed, and finally succumbed Oct. 3d."

An examination of the body was made by Dr. Webber, 23 hours *post mortem*, who reported the following appearances:—

"In the œsophagus, about four inches below the epiglottis, was a fungous, cauliflower-like mass nearly filling the calibre so as scarcely to allow the finger to pass, and fully three inches long. Above the main part of the growth were several small nodules of the same.

"In the trachea, at its bifurcation, was a mass of disease half an inch in diameter. On right of trachea, nearly opposite apex of lung, was a mass of disease which involved the pleura, if not the lung. Neighboring glands much enlarged. Under the microscope, the growth appeared to be epithelial. Right lung at apex very firmly adherent, lung tissue being torn in its removal. Cavity at apex, of the size of a pigeon's egg. A part of cavity contained gangrenous-smelling pus. Surrounding lung tissue consolidated. The tissue around the cavity seemed consolidated from inflammatory action. The apex was firmly adherent to the morbid growth, and there was a nodule of almost cicatricial hardness at that spot, near the border of the cavity. A section, examined microscopically, showed only inflammatory products."

Dr. Knight said that the case was particularly interesting to him, as it showed that even a *small cavity with rigid walls* could give rise to a *low-pitched* cavernous respiration. Dr. K. said that many good auscultators denied altogether that this low-pitched blowing respiration, which was nothing like the bronchial, and which could only be confounded with the normal vesicular murmur, was indicative of a cavity. It is admitted, however, by Walsh, Flint and DaCosta, and an appreciation of it is implied in Barth and Roger.

Dr. Jackson and Dr. Webber were of the opinion that the lung disease was not of the same nature as that in the œsophagus.

Medical and Surgical Journal.

Boston: Thursday, November 24, 1870.

A FEW HINTS TO MEDICAL AUTHORS.

The season has now come for good, earnest, hard work for those members of the profession who are willing to lay aside, for a time, the scalpel and the pill-box, and take up the book and the pen for mental improvement and study. Our request for aid a few weeks ago was met with remarks on the hot weather, and the inability for any mental application experienced by our brethren; and, indeed, we felt indisposed to urge our friends, while ourselves suffering from the inclemencies of the summer. But now, the cooler weather puts vigor into our bodies and adds vital force to our minds; and writers of medical works and of the more ephemeral periodical literature should feel moved to use the pen for the illustration of their own thoughts and the good of the profession.

Our medical literature contains a great deal of trash—let us start with that dictum—and how are we to get rid of it? As Editors, we constantly find ourselves obliged to wade through many bushels of chaff in the medical journals of the day for the few grains of wheat concealed somewhere in its depths, and we feel constantly impelled to inquire why this article was written or that book put forth, to mystify the truths which we need all possible light to illuminate. We cannot fail often to see the utter professional ignorance which all the sophistry of words cannot conceal; we cannot help feeling that the practice of a brother must be very limited and his opportunities of investigation very confined, when he is forced to magnify some apparently very common malady into a "unique case"; the veil of a cunningly related case, to which Dr. X. has been called, is generally too thin to conceal from an experienced eye the charlatanry of his advertising, a veil which, like the *coa vestis*, serves only to make more manifest that which it cannot conceal. Altogether there *is* a great of trash in our medical literature.

A good medical article or book should start with certain well grounded principles; sound truth for its basis, a thorough knowledge of the subject under treatment, in its author's mind, a clear and concise method of putting it into language, in a style which shall be attractive to the mind of the average physician. Could we but find these characteristics in all the works of the profession, we might with pride call ours a learned profession, and our literature in its way might hold equal rank with the living, inspiring words of the pulpit and the forum.

Truth cannot exist in the medical book without it is first found in the writer; a knowledge of the subject cannot be attained without actual professional study and investigation. Behind that we need higher and higher qualifications in our schools before giving the medical degree, and still farther back we should look for a more advanced standard of preliminary education. Indeed, in this last view of the matter, we feel our Medical Schools are behind the day. When they are willing to require the more elevated attainments which the growing age demands, before granting their license to practice; when they are disposed to demand as a starting point a more thorough mental and literary training, then, and not till then, may we look for good authors and good members of a learned profession.

We are merely hinting at suggestions which we wish might guide our author brethren: but if such suggestions as these had but presented themselves to the medical authors of the past score of years, we should have had less chaff and more wheat; less of the roar of the cannon and scream of the shell, and more of the precision of the rifle; fewer tons of ore, and more ounces of the precious metal; less volumes of words, and more pages of truths.

We cannot refrain in conclusion from quoting a wise criticism from a memorial article in the Edinburgh Medical Journal for August, on a distinguished member of our profession, lately deceased. The author says:

"Syme's 'Principles of Surgery' is also in many respects a very remarkable book.

"Firstly, The fifth and last edition is smaller than the first.

"Secondly, It is very brief; not an unnecessary word is inserted. The whole object of the book is to give only what information is needed, in as few and simple words as possible. It reminds one of Mr. Syme's lectures, in which his only object seemed to be to give the maximum of instruction in the minimum of words.

"Thirdly, It is written in plain, simple English, and contains not a slovenly phrase or an ill-constructed sentence.

"Fourthly, It encourages the reader to think and reason for himself, and shows how the treatment of the infinite varieties of disease are all based on a few broad and safe principles, and thus escapes the snare of burdening the memory with masses of antiquated quotation, or crude novelties of treatment. Hence its wonderful popularity and freshness. It is old, but not stale. Syme might have put on its title page the motto lately used by one of his most distinguished pupils :—

> 'Non hypotheses condo, non opiniones vendito,
> Quod vidi, scripsi.'"

Iodide of Potassium in Asthma. *Messrs. Editors,*—Much has been said and written in past years upon the merits and demerits of the Iodide of Potassium in Asthma.

And of late, I notice, a writer has been treating the subject, and regards its application as more especially appropriate to bronchial asthma; he relates a case in which he exhibited the drug in large and oft repeated doses, with complete success, for that time, but failed most signally with this treatment in a future attack of the same patient, soon after.

Now, sir, I am not disposed to criticize that writer's views of the disease, or his practice, for he is evidently on the right track and in good season.

But I think he is in too much hurry, and treats the patient with too large doses, and repeats them too often; he, in fact, feeds his patient with a powerful and potent remedy too rapidly, faster than the system can appropriate it; and hence the absorbents and secernents are to a certain extent over-charged, surfeited, and perhaps for a time paralyzed; and in the future have either no desire for that kind of stimulus, or are unable to receive it.

It has been my painful privilege and experience to know much of this disease for a period of over fifty years, by personal acquaintance. I inherit it as an heir-loom from two generations before me; and by that same law of transmission, it outcrops again in the one which follows me. I have met the disease in most or all of its phases, in my own person and in the sick room, and have treated it in all its forms; the dry, the humid, the spasmodic or bronchial, and the more fearful emphysema. I say more fearful, because the conditions of this disease are such as to render it of greater duration, equally or more distressing, and affording no hopes of cure, and but little prospect of relief.

I, too, have often administered this drug, and like the writer alluded to, have met with varied effects, but think I have seldom found a case where it lost its effect so absolutely or so soon, although such instances may occur.

In my own case, although constitutional, it is bronchial, spasmodic and nervous. I have used the remedy for years, to be counted by tens, perhaps by twenties. And yet it has never failed me, and is thus far ever sure to be a remedy of inestimable value on every occasion of attack; but I never give such large doses, seldom more than five grains a day, and that at bedtime. And if threatened or attacked, this quantity taken in the evening usually insures me a night of comfortable rest, with ability to resume my daily labor on the following day. But I do not repeat the dose unless the attack is also repeated; and here, it seems to me, is the cause of the success in one case and of the failure in the other, for, surely, I have ever found it a most valuable remedy for myself and others thus affected. Nor do I find its benefits apply to the bronchial form only, but regard it as an available and reliable remedy in other forms also, and in none have I found it to fail completely, unless in that peculiar form or stage when the diaphragm is seemingly flexed and immovable like a sheet of iron across the trunk, and the patient in a gasping state.

Here the iodide does fail, and here, if ether or chloroform affords no relief, remedies are of little use.

J. P. Whittemore, M.D.

Haverhill, November, 1870.

Admission to the Massachusetts Medical Society.—We had thought that the information contained in the Journals of the past few weeks was sufficient to settle the exact position of the Society in regard to admissions. As an answer to numerous inquiries, however, we are requested to state that, at present, *no one can enter the Massachusetts Medical Society without examination*. The Board of Censors for Suffolk District and for the Society at large will meet, according to the By-Laws, on the days succeeding the examinations in the Medical Department of Harvard University, and on the Thursday preceding the annual meeting of the Society, at the house of the Secretary, Dr. B. Joy Jeffries, 15 Chestnut street, Boston, at 4 o'clock, P.M.; also at 10 o'clock, A.M., on the day and at the place of the annual meeting of the Society.

Herpes Ophthalmicus.—B. T. Vernon (*St. Bartholomew's Hosp. Rep.*, IV., 1868) speaks of cases of *Herpes Ophthalmicus*. All parts of the fifth nerve may be affected either isolated or in combination. Neuralgia may occur solely or together, with herpetic eruptions on the eye-ball and its surroundings (phlyctenular ophthalmia and herpes zoster frontalis); but also paralytic affections of some branches of the oculomotor nerve are observed simultaneously, and this may be, perhaps, only a curious coincidence, but also in causative relation with the affection of the trophic or sensitive functions of the fifth pair.—*Medical Record.*

Medical Miscellany.

Long Island College Hospital—New Hospital Building.—We learn that the Regents of the Long Island College Hospital, Brooklyn, N. Y., finding their present accommodations insufficient, are engaged in the erection of a new building, to be completed and ready for the reception of patients by the 1st of March ensuing. The new wing will be about 150 feet front and three stories high, and is to be constructed on the most approved principles of modern hospital structures. Part of it will be occupied as an amphitheatre and operating room.

Biographical Dictionary of Deceased American Physicians.—Dr. J. M. Toner, of Washington, D. C., is desirous of obtaining information which will aid him in the publication of a Biographical Dictionary of Deceased American Physicians. The work is already in a state of considerable forwardness, and is designed to contain a biographical sketch of every deceased practitioner of regular medicine, from the earliest settlement of our country to the present time.

Hundreds of physicians have died in different parts of the United States, after devoting a long and useful life to their profession, of whose existence and labors there is no record. This should not be so. The want of a work furnishing an outline of the lives of American physicians has long been felt; and that the project meets the approbation of the profession and of the relatives of deceased medical men, has already been evinced by valuable contributions from different parts of the country.

The success of the undertaking must obviously depend, in a great measure, upon the coöperation of the medical profession, and such relatives and acquaintances of deceased physicians as may have it in their power to communicate the essential information.

Diphtheritic Paralysis.—Dr. Leube reports a case (*Arch. f. Klin. Med.*), in which, in addition to the loss of motor power, there were lowering of the sensibility of the skin and complete loss of sensation in the mucous membrane of the larynx above the free border of the vocal cords; whilst coughing was excited as soon as a sound was passed below the glottis. The difference is explained by the lower part being supplied by the tracheal branch of the recurrent as well as by the superior laryngeal nerve. The patient was fed for ten days by means of an œsophageal tube, and treated with strychnine, injected subcutaneously, in doses of one twelfth to one fourth of a grain daily. The improvement was rapid in all the symptoms.—*Dub. Med. Press & Circular.*

Optic Neuritis.—Dr. Hughlings Jackson, in cases of hemiplegia, has noticed this affection in greater frequency in connection with left-sided paralysis.

In lesions of the encephalon or meninges, Bouchut believes it is in general more marked in the eye corresponding to the hemisphere which is more seriously affected; Dr. Jackson, however, denies the existence of any relation between the side of the brain diseased and the eye affected.—*N. Y. Medical Record.*

Nitrobenzole.—This substance, which operates as a narcotic poison in vapor as well as in a liquid state, may, in the rapidly fatal cases, produce coma, which may be mistaken for the insensibility of apoplexy. But the poison leads quickly to death when coma has been induced, and is detected by its strong odor, resembling that of bitter almonds.—*Da Costa's Diagnosis.*

In the eleven medical schools of London 433 matriculants have been registered this year.

Correction.—On page 321, second column, 11th line from foot, for "seems" read *serves*.

To Correspondents.—Communications accepted:—The Ague Theory.—Death from Ether.

Books and Pamphlets Received.—The Transactions of the American Medical Association. Vol. XXI. 1870. Pp. 612.—Constitution and By-Laws of the Medical Library and Journal Association of New York. Pp. 16.—Transactions of the Medical Society of the State of West Virginia. Pp. 82.—Syphilis of the Nervous System. By E. L. Keyes M.D., Bellevue Hospital, New York. Pp. 44.—On the Uses of Wines in Health and Disease. By Francis E. Anstie, M.D., F.R.C.P., Editor of the London Practitioner. New York. Pp. 84.—The Illustrated Annual of Phrenology and Physiognomy for 1871. By S. R. Wells, Editor of the Phrenological Journal and Life Illustrated. Pp. 70.

Married,—In this city, Nov. 18th, Dr. George Faulkner to Miss Abbie S. Adams.

Deaths in fifteen Cities and Towns of Massachusetts for the week ending Nov. 19, 1870.

Cities and Towns.	*No. of Deaths.*
Boston	103
Charlestown	14
Worcester	17
Lowell	17
Milford	4
Chelsea	2
Cambridge	14
Salem	6
Lawrence	15
Springfield	7
Lynn	5
Taunton	2
Newburyport	2
Fall River	18
Haverhill	2
	228

Prevalent Diseases.	
Consumption	49
Croup and Diphtheria	13
Scarlet fever	10
Typhoid fever	9
Pneumonia	12
Dysentery & Diarrhœa	8

George Derby, M.D.,
Secretary of State Board of Health.

Deaths in Boston for the week ending Saturday, Nov. 12th, 103. Males, 55; females, 48. Accident, 3—apoplexy, 2—inflammation of the bowels, 1—bronchitis, 5—inflammation of the brain, 2—congestion of the brain, 1—disease of the brain, 1—burned, 1—cancer, 3—consumption, 25—convulsions, 1—cyanosis, 2—debility, 3—diarrhœa, 2—dropsy 5—dropsy of brain, 1—drowned, 1—dysentery, 1—diphtheria, 1—epilepsy, 1—erysipelas, 2—scarlet fever, 6—typhoid fever, 2—gastritis, 1—disease of heart, 5—disease of the kidneys, 2—disease of the liver, 2—inflammation of the lungs, 5—old age, 4—paralysis, 2—purpura, 1—premature birth, 1—puerperal disease, 1—scalded, 1—suicide, 1—tetanus, 1—unknown, 3—whooping cough, 1.

Under 5 years of age, 32—between 5 and 20 years, 8—between 20 and 40 years, 23—between 40 and 60 years, 19—above 60 years, 21. Born in the United States, 67—Ireland, 26—other places, 10.